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per QALY gained. Multiple sensitivity analyses were undertaken to test the robustness of the model including both one-way sensitivity analyses and multivariate probabilistic sensitivity analyses using Monte Carlo simulations. **RESULTS:** PP-LAI treated patients were in remission 249 days and accumulated a total of 0.633 QALYs at a cost of 89,360 NOK. OLZ-LAI treated patients were in remission 243 days and accumulated a total of 0.621 QALYs at a cost of 100,888 NOK. The result was that PP-LAI was the dominant treatment strategy (more effective and less costly). Results were robust over a wide range of sensitivity analyses tested. The main drivers of the model included compliance rates and the price of each pharmacotherapy, with PP-LAI being less costly than OLZ-LAI. **CONCLUSIONS:** PP-LAI was cost-effective compared with OLZ-LAI in the treatment of schizophrenia in Norway.

PMH36

COST-EFFECTIVENESS OF DEPOT FLUPENTIXOL VERSUS LONG-ACTING RISPERIDONE – A MARKOV MODEL PARAMETERIZED USING ADMINISTRATIVE DATA

Frey S[1], Stargardt T[1], Linder R[2], Juckel G[3]
[1]*University of Hamburg, Hamburg, Germany,* [2]*Scientific Institute of TK for Benefit and Efficiency in Health Care, Hamburg, Germany,* [3]*LWL-Universitätsklinik Bochum, Bochum, Germany*

OBJECTIVES: To use administrative data in a Markov simulation that compares the cost-effectiveness of depot flupentixol and long-acting risperidone in the treatment of schizophrenia. **METHODS:** We employed a Markov model to simulate treatment for schizophrenic patients during 24 cycles with a cycle length of 30 days. The model comprised three non-absorbing states, i.e. inpatient treatment, outpatient treatment with the patient either being compliant or not, and three absorbing states, i.e. switching from index medication, death and dropout. Compliance was defined using a refill persistence measure. Treatment costs from the payer's perspective, i.e. cost of outpatient, inpatient and pharmaceutical care, and hospitalization were used as outcomes. Transition probabilities between Markov states and outcomes for each state were estimated from an administrative dataset comprising 935 patients who were hospitalized with schizophrenia (ICD-10:F20) between 2005 and 2008 and who subsequently received depot flupentixol or risperidone. It was adjusted for age, sex, prior hospitalization, prior sick leave, early retirement, and comorbid conditions according to the Elixhauser score using multinomial logistic and gamma regression models, respectively. **RESULTS:** Cohort simulation based on 1000 patients on average aged 40.8 years, 55.0% male with 38.0 days of prior annual hospitalization, showed that 102 (266) patients treated with flupentixol (risperidone) remained in a non-absorbing state after 24 cycles. Thus switching to other antipsychotics occurred more often with flupentixol. Average cost of treatment with flupentixol (risperidone) was 544.52 € (1,109.67 €) per patient and cycle. While patients treated with flupentixol were hospitalized more often compared to risperidone (5.2% vs. 4.8% per cycle), length of hospitalization was lower with flupentixol as compared to risperidone (16.11 vs. 16.53 days). **CONCLUSIONS:** The effectiveness of depot flupentixol in preventing relapse appears to be similar to long-acting risperidone. While treatment costs were lower with flupentixol, switching rates seem to be higher.

PMH37

COST-MINIMISATION ANALYSIS OF ASENAPINE MONOTHERAPY VERSUS OTHER ANTIPSYCHOTICS IN BIPOLAR I DISORDER IN TWO NORDIC COUNTRIES

Despiégel N[1], Davie AM[2], Corson H[3], Beillat M[3], Sapin C[3]
[1]*OptumInsight, Nanterre, France,* [2]*OptumInsight, Uxbridge, Middlesex, UK,* [3]*Lundbeck SAS, Issy les Moulineaux cedex, France*

OBJECTIVES: To evaluate the treatment management cost, over 12 weeks, of asenapine relative to quetiapine, olanzapine, and aripiprazole which are currently used in Finland and Sweden to treat moderate to severe manic in bipolar I disorder. **METHODS:** A cost-minimisation analysis was conducted from a Finnish and Swedish societal perspective. Costs were the only consideration due to similar clinical efficacy of asenapine demonstrated in active controlled non-inferiority clinical trial vs olanzapine and through indirect comparisons with quetiapine and aripiprazole. Due to significant differences in adverse events and healthcare system costs, we included management of weight gain, akathesia and insomnia. Patients were assumed to start treatment as an inpatient for the first month of therapy, and then followed for two months in an outpatient setting. All direct and indirect resource use and unit cost estimates were derived from the latest available sources and literature. No evidence exists suggesting any differences with respect to healthcare management (e.g. hospitalisation) between treatment strategies. Thus, estimated resource use and costs applied were assumed the same across treatment strategies. Deterministic sensitivity analyses were conducted to explore uncertainty around input parameters. **RESULTS:** The estimated direct cost of treatment and of the management of adverse events related to treating adults with bipolar I disorder suffering a manic or mixed episode for 12 weeks with asenapine monotherapy for Finland and Sweden were respectively: €421 and €670 (SEK 6,044) compared to €502 and €1139 (SEK 10,257; aripiprazole), €141 and €827 (SEK 7,453; quetiapine), and €344 and €957 (SEK 8,616; olanzapine). **CONCLUSIONS:** Asenapine has been shown to be cost saving relative to aripiprazole in Finland and to quetiapine, olanzapine, and aripiprazole in Sweden at the short-term endpoint of 12 weeks. The estimated treatment cost represented less than 6% of the overall burden of bipolar disorder from societal perspective.

PMH38

BUPRENORPHINE/NALOXONE VERSUS BUPRENORPHINE AND METHADONE IN HEROIN ADDICTION DETOXIFICATION: AN ITALIAN COST-UTILITY ANALYSIS

Marino V[1], Lazzaro C[2]
[1]*ASL Varese, Varese, Italy,* [2]*Studio di Economia Sanitaria, Milan, Italy*

OBJECTIVES: prevalence of heroin addiction among Italian population aged 15-64 is 0.8%. Three different drugs are currently available for treating heroin addiction: methadone, buprenorphine and buprenorphine/naloxone. A monocenter, retrospective, one-year follow-up cost-utility analysis (CUA) was performed to compare buprenorphine/naloxone (211 patients) vs buprenorphine (214 patients) and methadone (512 patients) for heroin addiction detoxification at Department of Addictions, Local Health Authority of Varese, Italy. **METHODS:** CUA adopted the Department of Addictions viewpoint. Clinical, economic and utility data were obtained from the database of the Department of Addictions and literature. Drugs, bottles for methadone take-home doses, health care and social services were identified, quantified and valued in Euro (€) 2009. One-way and probabilistic sensitivity analyses (SAs) were performed. **RESULTS:** 87.8% of patients are male. Mean (±standard deviation) patients' age is 37.9±7.2 years, whereas patients' first contact with heroin dates back to 16.7±8.5 years. Neither heterogeneity nor sample selection bias have been detected among treatment groups. Buprenorphine and methadone are the most and the least costly options (€3257.24 and €2219.47 per patient, respectively). Buprenorphine/naloxone costs €2541.05 per patient. During one-year follow-up patients accrue 0.573 (methadone), 0.599 (buprenorphine) and 0.602 (buprenorphine/naloxone) Quality-Adjusted Life Years (QALYs). Buprenorphine is strongly dominated by buprenorphine/naloxone and hence ruled out from the base case CUA. The incremental cost-utility ratio for buprenorphine/naloxone vs methadone is €11,195.12. SAs confirm the robustness of the base case findings. Cost-Effectiveness Acceptability Curve shows that the probability for buprenorphine/naloxone to be cost-effective equals 0.58, 0.61 and 0.62 against €25,000, €40,000 and €50,000 threshold-values, respectively. Cost-Effectiveness Acceptability Frontier highlights that buprenorphine/naloxone is the optimal alternative from a threshold-value of €11,391.14. **CONCLUSIONS:** Buprenorphine/naloxone seems advisable even from an economic point of view, since its incremental cost-utility ratio falls well within the usual acceptability standards for incremental QALY saved (€25,000-40,000; €50,000).

PMH39

COST EFFECTIVENESS OF A COLLABORATIEVE CARE STEPPED INTERVENTION FOR ANXIETY DISORDERS IN THE PRIMAIRY CARE SETTING

Goorden M[1], Muntingh A[2], Balkom AJ[3], Van marwijk HW[4], Spinhoven P[5], De waal MW[6], Assendelft PJ[6], van der Feltz-Cornelis CM[7], Hakkaart - van Roijen L[8]
[1]*institute for Medical Technology Assessment, Rotterdam, Zuid Holland, The Netherlands,* [2]*Trimbos Institute, Utrecht, Utrecht, The Netherlands,* [3]*VU University medical centre (VUmc), Amsterdam, Noord Holland, The Netherlands,* [4]*Institute for Health and Care Research of VU University medical centre (VUmc), Amsterdam, Noord Holland, The Netherlands,* [5]*Leiden University, Leiden, Zuid Holland, The Netherlands,* [6]*Leiden University Medical Center, Leiden, The Netherlands,* [7]*University of Tilburg, Tiburg, The Netherlands,* [8]*Erasmus Universiteit Rotterdam, Rotterdam, Zuid Holland, The Netherlands*

OBJECTIVES: To evaluate the cost-effectiveness of a collaborative stepped care intervention (CSC) for panic disorder and generalised anxiety disorder in primary care compared to care as usual (CAU). **METHODS:** A two armed cluster randomised controlled trial, 43 primary care practices participated in the study. Patients selected by their general practitioner and patients selected from files screening positive on an anxiety screener, had a MINI International Neuropsychiatric Interview to classify DSM-IV disorders. Eventually, 180 patients with a diagnosis of panic disorder or generalised anxiety disorder were included in the study (114 collaborative stepped care, 66 care as usual). Baseline measurements and follow up measures (3, 6, 9 and 12 months) were assessed using questionnaires. We applied the TiC-P and the EQ-5D respectively assessing the health care utilization, production losses and general health related quality of life. The incremental analysis indicated costs per QALY. **RESULTS:** The average annual direct medical costs in the collaborative stepped care group were 1987 Euro (sd 2027), compared to 1645 Euro (sd 1844) in the care as usual group. The average quality of life years (QALY's) gained was higher in the collaborative stepped care group compared to the care as usual group, 0.08 QALY. The incremental cost utility was about 4100 euro per QALY. Including both the direct medical costs and productivity costs the collaborative stepped care group dominated CAU. **CONCLUSIONS:** The study showed that CSC is a cost effective intervention for anxiety disorder in the primary care setting and even dominant including productivity costs.

PMH40

ECONOMIC EVALUATION OF AGOMELATINE FOR MAJOR DEPRESSIVE DISORDER IN AUSTRALIA

O'Leary BA[1], Hamann GB[2], Adena MA[3]
[1]*Covance Pty Ltd, North Ryde, NSW, Australia,* [2]*Servier Laboratories (Aust) Pty Ltd, Hawthorn, VIC, Australia,* [3]*Datalytics Pty Ltd, Bruce, ACT, Australia*

OBJECTIVES: Despite the availability of numerous antidepressants, persistence with treatment is poor and adverse events are a key factor. Agomelatine is a new chemical entity for the treatment of major depressive disorders (MDD) with a placebo-like side effect profile resulting in a statistically significantly higher proportion of patients continuing treatment compared with venlafaxine. The objective of this study was to conduct a cost-utility analysis of agomelatine compared with venlafaxine from an Australian healthcare perspective to inform reimbursement decision making by the Pharmaceutical Benefits Advisory Committee (PBAC). **METHODS:** An Excel-based Markov model was developed with four states 'depressed', 'remission', 'well' and 'death' with a three year time-horizon. Agomelatine and venlafaxine were assumed to be equally effective in the treatment of depressive symptoms but to differ in discontinuation rates, requirement for down titration and costs. Patients enter the model in the 'depressed' state and can progress to 'remission' where they may relapse and re-enter 'depressed' or move to the 'well' state (after spending six months in 'remission'). Patients in the 'depressed' or